

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-046981  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 1928

**FILED DEC 18 1962**

VS 300  
Rev. 4/59

6128  
20730

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125-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>NEW MADRID</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>55 DAYS</b>	c. CITY OR TOWN <b>MARSTON</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA. HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>NSA</b>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>GUY</b> Last <b>NEAL</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>10</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-15-94</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHERIFF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>	9. AGE (last birthday) <b>68</b>
11. BIRTHPLACE (City and state or country) <b>HUNTINGTON, TENN</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JAMES NEAL</b>		13b. MOTHER'S MAIDEN NAME <b>ALLICE GARNER</b>	
14. NAME OF HUSBAND OR WIFE <b>EMMA L. NEAL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>VA. HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>MYOCARDIAL INFARCTION OLD</b> DUE TO (c) <b>CORONARY OCCLUSION</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>PULMONARY FIBROSIS &amp; EMPHYSEMA</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? <b>YES</b>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>6:10AM</b> Month, Day, Year <b>10-16-62</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. <b>VA</b> amended the deceased from <b>10-16-62</b> to <b>12-10-62</b> Death occurred at <b>6:10AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>DAVID W. MILLER M.D. Medical Pathologist</b>		22b. ADDRESS <b>VA. HOSPITAL POPLAR BLUFF, MO.</b>	22c. DATE SIGNED <b>12-10-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/12/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Portageville Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Portageville, Missouri</b>
24. FUNERAL DIRECTOR <b>DeLisle Funeral Home</b>		25. DATE RECD. BY LOCAL REG. <b>12/14/1962</b>	26. REGISTRAR'S SIGNATURE <b>Thelma Graham</b>

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Joseph C. [Signature]*

Licensed Embalmer No. 4481

P. O. Address Polkville, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.